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ABSTRACT

A foster-family-based treatment program recruits couples from the community that are willing to learn a set of treatment procedures and accept a disturbed or disturbing child or youth into their family. The couples apply the learned procedures consistently, and under supervision, while they also provide good care and parenting. Though superficially similar to foster care, foster-family-based treatment exists for the purpose of providing treatment, and not just food, clothing, and protection. Ten aspects differentiate the two types of services. A recent development, foster-family-based treatment does not fit neatly into any existing discipline, such as social work, special education, or psychology. Its intrinsic advantages include minimal restrictiveness and maximal generality with regard to the behaviors and situations it can address. Experience with the treatment indicates that foster-family-based treatment can also be intensive, in that it uses several powerful treatment technologies that converge to yield major changes in very significant behaviors. (RH)

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Foster-Family-Based Treatment: What Is It?

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Foster-Family-Based Treatment: What Is It?

It has been known for over 20 years that children's parents can be trained to treat at least some kinds of child maladjustment quite effectively. This was first demonstrated experimentally in the 1950s and 1960s (Hawkins, Peterson, Schweid, & Bijou, 1966; Risley & Wolf, 1966; Wahler, Winkel, Peterson, & Morrison, 1965; Williams, 1959; Wolf, Risley, & Meese, 1964; Zeilberger, Sampen, & Sloane, 1968). Since then, parent training has become an increasingly popular and effective intervention for treating an increasing variety of children's psychological problems (cf. Gordon & Davidson, 1981), with the result that there now is a massive body of research and therapeutic technology related to parent training.

Training parents to modify their own child's behaviors can have several advantages. First, since a parent's interventions take place in the context of longstanding interpersonal relationships and involve numerous material, social, and activity contingencies, those interventions can be made quite powerful. Second, much, if not all, of the treatment takes place in the very settings where the child's adjustment difficulties exist, so that generalization of behavior changes is either no issue or much less of one. Third, if the parent--or another person--records daily, objective data on their own implementation of intended procedures or on the child's behavior, these data will provide a kind of on-the-spot feedback that serves to reinforce effective treatment procedures and prompt timely adjustments in

those procedures. These advantages have no doubt been among the reasons for the popularity of parent training.

If a child's <u>own</u> parents can teach him or her to behave in more effective, adaptive ways, then it seems likely that substitute parents could do the same. This was the hypothesis behind the development of Achievement Place, a group home at University of Kansas in which one couple treats up to eight disturbing boys in a home environment (Phillips, 1968). Achievement Place served as the prototype for a nationwide network of group home programs that have proven effective in treating a very difficult group of youngsters (Kirigin, Braukmann, Atwater, & Wolf, 1982).

If one couple can learn to treat <u>several</u> youngsters effectively at the same time, in a group home, surely they could learn to be even more effective with only one or two youngsters. This is the hypothesis that has led a few agencies in the country to establish what we call "foster-family-based treatment" or, sometimes, simply "family-based treatment" (e.g., Hawkins, 1987; Hawkins, Meadowcroft, Trout, & Luster, 1985; Meadowcroft, Hawkins, Trout, Grealish, & Stark, 1982).

In foster-family-based treatment one recruits couples from the community who are willing to learn a set of treatment procedures, then accept a disturbed or disturbing child or youth into their family who has been removed from his/her home for one or more reasons. The couples then apply the learned procedures consistently, under supervision, along with just plain good care and parenting.

Foster-family-based treatment is like good treatment in a residential treatment center, in that a system of procedures is applied consistently throughout the day. But the persons applying those procedures, the "treatment parents," remain constant 24 hours a day, 365 days a year. They come to know the youngsters much more initimately than do shift staff, and the youngster's daily behavior and progress become very important to them. By the same token, the youngster has much more incentive to behave well because s/he comes to care about this family who has accepted him/her into their lives, and because the family members influence important consequences for him/her for months or even years into the future.

Foster-family-based treatment is also similar to foster care, in that the family providing the treatment is, technically, a foster family. But the service exists for providing treatment, not simply food, clothing, and protection. Thus, we prefer not to refer to it as "foster care," "specialized foster care," or even "treatment foster care"--as do some professionals--because the essence of it is not simply "care" but also treatment (Hawkins, 1987).

In comparing foster-family-based treatment to foster care, ten variables seem to differentiate the two (Hawkins, 1987). First, the parents who enter such a paraprofessional or semiprofessional role must have better intellectual skills, interpersonal skills, and other qualifications than a parent who provides only foster care. Second, the parent must acquire a well-planned set of skills to a specified criterion of

performance. Third, the agency must provide intensive inservice support and supervision, such as 24-hour, on-call advice, reassurance and assistance so that the parent can deal effectively with the numerous problems that arise; continued training and education in the home and in group meetings; a rich staff/client ratio (e.g., 1/7 or even 1/3); ample recognition and respect; and at least twice as much financial remuneration as in foster care (Meadowcroft, 1987). Fourth, the treatment procedures must include powerful techniques and must be applied in all situations to any behavior that is relevant to treatment goals. Fifth, intervention must also be made through other parties who influence the youngster, especially school personnel, the youngster's natural parents, friends, and siblings. Sixth, the parent supervisor or case manager, to use a term from People Places in Virginia (Bryant, 1980), must be very resourceful, socially adept, experienced with youngsters, and either trained in the treatment approach employed or open to learning it. Seventh, the agency must train the case manager in the skills of his/her role, not assume that a degree, certificate, or license is sufficient training. Eighth, like the treatment parent, the case manager has a very demanding job and needs ample support and supervision in performing it. Ninth, because the program is involved in such a wide range of settings and issues, it is important to not only have a significant percentage of professional staff with clinical training, but also a mixture of other backgrounds such as education, special education, educational psychology, vocational rehabilitation, social work,

and so on. And tenth, a good foster-family-based treatment program will document extensively the intended procedures, the procedures actually implemented, the characteristics of the youngsters they serve, and the effects of the treatment procedures on the behavior of the youngster and perhaps on his/her natural family.

Foster-family-based treatment is a recent development, for the most part, and it does not fit neatly under any existing discipline, such as social work, special education, or psychology. It has the intrinsic advantages of being minimally restrictive and maximally broad or general in terms of the behaviors and situations it can address. We believe that foster-family-based treatment can also be intensive, in the sense of using several powerful treatment technologies that converge to yield major changes in very significant behaviors. We have, in fact, seen that happen in many of the children and youth whom we have served. Our goal is to find out how to make it happen in as nearly all of them as possible.

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FOSTER FAMILY-BASED TREATMENT COMPARED TO FOSTER CARE

1. Parents must have better skills and resources.
2. Parents must be trained to performance criteria on a well-planned set of treatment skills.
3. Agency support and supervision must be intensive: 24 hour on-call, reasonable payments, inservice training, recognition and respect like a semiprofessional, etc.
4. Treatment procedures must include powerful techniques and be applied to any treatment-relevant behaviors in any situation.
5. Other mediators must be included: teachers, natural parents, friends, siblings, etc.
6. Skillful, resourceful, experienced case managers.
7. Agency must train case managers in both the parent's procedures and management skills.
8. Ample support and supervision of case managers must be given.
9. Diverse staff that includes clinically-trained but also others.
10. Procedures and outcomes must be documented regularly, preferably including daily.

FOSTER FAMILY-BASED TREATMENT
COMPARED TO
RESIDENTIAL TREATMENT

1. Similar in terms of direct treatment staff qualifications, training, and procedures.

2. Much less restrictive (more normal), making possible a wide variety of incidental learning of normal behaviors, values, etc., plus a greater range of tasks and consequences.

3. Better use of funds, since less goes to buildings, maintenance, etc.

4. Youth's parents likely to be served and involved more.

5. Assessment and treatment more continuous, relevant to normal living, and individualized.

6. Because youth are not grouped, they do not teach each other maladaptive behaviors and values.

7. Can serve a very broad range of clients in same program.